		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040691

Facility Name: ALDEN TERRACE OF MCHENRY REHAB

Address: 803 ROYAL DRIVE (Number) MCHENRY (City) 60050 (Zip Code)

County: MCHENRY

Telephone Number: (815) 344-2600 **Fax #** (815) 344-5414

IDPA ID Number: 36-4003491

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: STEVEN M. KROLL **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) STEVEN M. KROLL
(Title) CHIEF FINANCIAL OFFICER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	316	Skilled (SNF)		115,656	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	316	TOTALS		115,656	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,745	1,432	2,798	10,975	8
9	SNF/PED					9
10	ICF	49,987	9,704	816	60,507	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,732	11,136	3,614	71,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.81%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
daycare

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 2,650

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/01/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAE # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	280,208	54,805		335,013	196	335,209		335,209			1
2	Food Purchase		511,746		511,746	(49,747)	461,999	(1,207)	460,792			2
3	Housekeeping	192,439	39,635		232,074	595	232,669		232,669			3
4	Laundry	85,309	19,651		104,960	136	105,096		105,096			4
5	Heat and Other Utilities			217,561	217,561		217,561		217,561			5
6	Maintenance	27,176		187,920	215,096	3,333	218,429	22,665	241,094			6
7	Other (specify):*											7
8	**TOTAL General Services**	585,132	625,837	405,481	1,616,450	(45,487)	1,570,963	21,458	1,592,421			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,522,089	135,570	12,347	2,670,006	650	2,670,656	2,804	2,673,460			10
10a	Therapy					36	36		36			10a
11	Activities	116,269	4,335	2,511	123,115		123,115	(7,476)	115,639			11
12	Social Services	49,990		52	50,042		50,042	(20,827)	29,215			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,688,348	139,905	29,310	2,857,563	686	2,858,249	(25,499)	2,832,750			16
	C. General Administration											
17	Administrative	55,903			55,903		55,903		55,903			17
18	Directors Fees											18
19	Professional Services			762,175	762,175		762,175	(667,401)	94,774			19
20	Dues, Fees, Subscriptions & Promotions			42,885	42,885	(3,333)	39,552	(26,928)	12,624			20
21	Clerical & General Office Expenses	611,990	21,374	27,778	661,142		661,142	35,682	696,824			21
22	Employee Benefits & Payroll Taxes			401,294	401,294	48,134	449,428	65,773	515,201			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,055	1,055		1,055	18,823	19,878			24
25	Other Admin. Staff Transportation			69	69		69		69			25
26	Insurance-Prop.Liab.Malpractice			80,556	80,556		80,556	200	80,756			26
27	Other (specify):*			12,000	12,000		12,000	(12,000)				27
28	**TOTAL General Administration**	667,893	21,374	1,327,812	2,017,079	44,801	2,061,880	(585,851)	1,476,029			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,941,373	787,116	1,762,603	6,491,092		6,491,092	(589,892)	5,901,200			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB #0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			44,909	44,909		44,909	11,413	56,322			30
31	Amortization of Pre-Op. & Org.							1,276	1,276			31
32	Interest			130,480	130,480		130,480	(989)	129,491			32
33	Real Estate Taxes			195,134	195,134		195,134	8,159	203,293			33
34	Rent-Facility & Grounds			2,306,800	2,306,800		2,306,800	90,350	2,397,150			34
35	Rent-Equipment & Vehicles			11,180	11,180		11,180	25,803	36,983			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,688,503	2,688,503		2,688,503	136,012	2,824,515			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,480	217,166	316,646		316,646	(66,646)	250,000			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,484	173,484		173,484		173,484			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		99,480	390,650	490,130		490,130	(66,646)	423,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,941,373	886,596	4,841,756	9,669,725		9,669,725	(520,526)	9,149,199			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ (7,476)	11	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,464)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,655)	32		18
19	Entertainment				19
20	Contributions	(3,842)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,661)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,395)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,537)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(501,159)		34
35	Other- Attach Schedule **see pg 5a**	37,170		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (463,989)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (520,526)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ALDEN TERRACE OF MCHENRY REHAB

ID# 00406/91

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost: part b therapy c/a's(pat. charges)	$ (4,009)	39	1
2	non-cost: hmo nurs.supply c/a(gl 5026)	(1,102)	39	2
3	non-cost: hmo therapy c/a (gl 5040)	(11,156)	39	3
4	non-cost: hmo drugs c/a (gl 5042)	(1,316)	39	4
5	back out painting exp. For 2000	(8,926)	6	5
6	record def. Maint. Exp on 1998 painting	7,927	6	6
7	record def. Maint. Exp on 1999 painting	2,811	6	7
8	record def. Maint. Exp on 2000 painting	1,488	6	8
9	record def. Maint. Exp on 1997 painting	3,902	6	9
10	back out marketing manager salary(non-allowable)	(20,827)	12	10
11	back out prior year adjust to gl 5018(registry)	3,584	10	11
12	Commun. Relations: gl 5726	(260)	20	12
13	McHenry Area chamber of commerce	(1,500)	20	13
14	back out prior year adjust to gl 5019(blood gluc coor)	5,824	19	14
15	aj rent expense to equal actual for yr 2000	90,350	34	15
16	reclass deprec exp on painting(1700) to line 6	(3,902)	30	16
17	reclass deprec exp on painting(1700) from line 30	3,902	6	17
18	back out related party commun relation salary	(29,620)	21	18
19				19
20				20
21				21
22				22
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87				87
88				88
89				89
90	**Total**	37,170		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,464)	0	0	257	0	0	0	0	0	0	0	(1,207)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	11,104	0	11,561	0	0	0	0	0	0	0	0	22,665	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	9,640	0	11,561	257	0	0	0	0	0	0	0	21,458	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	3,584	0	0	0	(780)	0	0	0	0	0	0	2,804	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,476)	0	0	0	0	0	0	0	0	0	0	(7,476)	11
12	Social Services	(20,827)	0	0	0	0	0	0	0	0	0	0	(20,827)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(24,719)	0	0	0	(780)	0	0	0	0	0	0	(25,499)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	5,824	0	(673,145)	0	0	0	0	(80)	0	0	0	(667,401)	19
20	Fees, Subscriptions & Promotions	(27,658)	0	730	0	0	0	0	0	0	0	0	(26,928)	20
21	Clerical & General Office Expenses	(29,620)	0	48,609	10,205	6,488	0	0	0	0	0	0	35,682	21
22	Employee Benefits & Payroll Taxes	0	0	65,791	0	(18)	0	0	0	0	0	0	65,773	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,823	0	0	0	0	0	0	0	0	18,823	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	200	0	0	0	0	0	0	0	0	200	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(63,454)	0	(538,992)	10,205	6,470	0	0	(80)	0	0	0	(585,851)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,533)	0	(527,431)	10,462	5,690	0	0	(80)	0	0	0	(589,892)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,902)	0	15,315	0	0	0	0	0	0	0	0	11,413	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	1,276	0	0	0	0	1,276	31
32	Interest	(9,699)	0	6,598	0	0	0	2,112	0	0	0	0	(989)	32
33	Real Estate Taxes	0	0	8,159	0	0	0	0	0	0	0	0	8,159	33
34	Rent-Facility & Grounds	90,350	0	0	0	0	0	0	0	0	0	0	90,350	34
35	Rent-Equipment & Vehicles	0	0	25,803	0	0	0	0	0	0	0	0	25,803	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	76,749	0	55,875	0	0	0	3,388	0	0	0	0	136,012	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(17,583)	0	0	(8,647)	(22,641)	0	(17,775)	0	0	0	0	(66,646)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(17,583)	0	0	(8,647)	(22,641)	0	(17,775)	0	0	0	0	(66,646)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,367)	0	(471,556)	1,815	(16,951)	0	(14,387)	(80)	0	0	0	(520,526)	45

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	see pg 6k….		see pg 6k….		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		see following pages…	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.	100.00%	$ 11,561	$ 11,561	15
16	V	19	professional fees	688,988	Alden Management Services, Inc.		15,843	(673,145)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		730	730	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		48,609	48,609	18
19	V	22	employee costs		Alden Management Services, Inc.		65,791	65,791	19
20	V	24	auto/seminar		Alden Management Services, Inc.		18,823	18,823	20
21	V	26	insurance		Alden Management Services, Inc.		200	200	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		6,598	6,598	23
24	V	33	real estate tax		Alden Management Services, Inc.		8,159	8,159	24
25	V	35	auto lease		Alden Management Services, Inc.		25,803	25,803	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 688,988			$ 217,432	$ * (471,556)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 20,252	Pyramid Health Care Services	0.00%	$ 20,509	$ 257	15
16	V	39	nursing supplies	7,378	Pyramid Health Care Services		6,853	(525)	16
17	V	39	supplies/per diem fees/misc	22,560	Pyramid Health Care Services		14,438	(8,122)	17
18	V	21	gen'l & admin		Pyramid Health Care Services		10,205	10,205	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,190			$ 52,005	$ * 1,815	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 75,758	Forum Extended Care II	0.00%	$ 57,025	$ (18,733)	15
16	V	10	house stock	3,152	Forum Extended Care II		2,372	(780)	16
17	V	39	iv	15,805	Forum Extended Care II		11,897	(3,908)	17
18	V	22	vaccinations	70	Forum Extended Care II		52	(18)	18
19	V	21	gen'l & admin		Forum Extended Care II		6,488	6,488	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,785			$ 77,834	$ * (16,951)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$ 182,451	COMMUNITY PHYSICAL THERAPY	100.00%	$ 164,676	$ (17,775)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		1,276	1,276	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		2,112	2,112	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 182,451			$ 168,064	$ * (14,387)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	construction management fee	$ 5,640	Alden Bennett Construction	0.00%	$ 5,560	$ (80)	15
16	V	19	design fee/achitectural	112	Alden Design Group		112		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,752			$ 5,672	$ * (80)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHA # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg	President-AMS	CEO	100.00	180,115	2.948	7.37	salary	$ 14,331	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	69,000	2.948	7.37	salary	5,490	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten.	b.	71,359	2.948	7.37	salary	2,261	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,851	0	0.00	fee	0	10a-3	4
5											5
6											6
7											7
8											8
9	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										9
10	b. Terry is the son-in-law of Floyd Schlossberg.He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										10
11	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										11
12											12
13								TOTAL	$ 22,082		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8a….				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAE # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CPT INTEREST	X		WORKING CAPITAL	NONE					VARIES	2,112	6
7	line of credit		x	WORKING CAPITAL	NONE					VARIES	120,825	7
8	related party…		x	WORKING CAPITAL	NONE					VARIES	6,598	8
9	TOTAL Facility Related						$	$			$ 129,535	9
	B. Non-Facility Related*											
10	LESS: INTEREST INCOME			offset interest expense with interest income							(44)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (44)	14
15	TOTALS (line 9+line14)						$	$			$ 129,491	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	193,533	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	189,593	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,940)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	199,074	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	195,134	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	179,195	8
	1996	175,805	9
	1997	180,705	10
	1998	184,317	11
	1999	189,593	12

LINE 4: 2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: $189,594 X 1.05 = $199,074

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,000 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NA

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7	316										7
8											8
	Improvement Type**										
9	CLIMATE SERVICE(VENTILATION)			1995	1,828	122	15	122		680	9
10	CLIMATE SERVICE(VENTILATION)			1995	1,915	128	15	128		702	10
11	CLIMATE SERVICE(CONTROLS)			1995	2,885	192	15	192		1,058	11
12	CLIMATE SERVICE(CONTROLS)			1995	1,251	83	15	83		459	12
13	CLIMATE SERVICE(A/C MOTORS,TRANSFMR)			1995	1,840	123	15	123		664	13
14	CLIMATE SERVICE(CONTROLS)			1995	1,200	80	15	80		427	14
15	J.D. & SONS(ROOFING)			1995	7,500	750	10	750		4,000	15
16	GREAT LAKES PLUMBING(REPLACE DISCH PUMP)			1995	3,563	238	15	238		1,267	16
17	MIDWEST ELECTRICAL(GARBAGE DISP. REPAIR)			1995	3,332	500	5	500		3,332	17
18	CLIMATE SERVICES(VENTILATION)			1995	2,295	153	15	153		791	18
19	CSI (NEW PUMP)			1995	1,483	148	10	148		754	19
20	EAGLE FLAG & BANNER(SIGN)			1995	680	57	12	57		298	20
21	Equipment International Ltd (repair washer)			1996	1,793	359	5	359		1,524	21
22	J. D. & Sons Roofing Co. (roof repair)			1996	7,700	770	10	770		3,465	22
23	ABC: (VENDOR:ARRIGO):ROOF TOP CONDENSOR)			1996	8,668	867	10	867		3,792	23
24	INSTALL WALK IN REFRIG. DOOR			1997	2,177	435	5	435		1,742	24
25	INSTALL CERAMIC TILES-FLOORING			1997	1,535	307	5	307		1,202	25
26	ENGINE/GENERATOR REPAIRED			1997	3,099	620	5	620		2,376	26
27	INSTALL NEW CYLINDER			1997	12,800	2,560	5	2,560		9,173	27
28	INSTALL NEW CONDENSER			1997	8,166	1,633	5	1,633		5,716	28
29	INSTALL NEW CYLINDER			1997	15,300	3,060	5	3,060		10,710	29
30	TILES INSTALLED-FLOORING			1997	4,102	820	5	820		2,666	30
31	HVAC BOILER			1997	5,888	1,178	5	1,178		3,631	31
32	CUSTOM WALL PLATES			1997	386	39	10	39		125	32
33	A&B CUSTOM CABLE-WALL PLATES INSTALLED			1997	1,918	192	10	192		623	33
34	CONTINUE....										34
35											35
36	TOTAL (lines 4 thru 35)				$ 103,306	$ 15,413		$ 15,413	$	$ 61,179	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wigdahl Electric (install new fixtures, relocate outlets)			1998	1,759	352	5	352		1,056	9
10	Wigdahl Electric (repair lighting, timeclock)			1998	1,853	371	5	371		1,112	10
11	Climate Service (repaired boiler)			1998	16,029	1,603	10	1,603		4,675	11
12	Atash (repair spinkler system)			1998	1,558	156	10	156		467	12
13	J.D. & Son (roof repair)			1998	10,000	1,000	10	1,000		2,500	13
14	CSI (dietary refrigerator)			1998	1,670	167	10	167		418	14
15	CSI (sump cover)			1998	4,900	490	10	490		1,143	15
16	Patten (generator repairs)			1998	3,856	193	20	193		466	16
17	CSI (insulate duct on air handler)			1998	2,750	183	15	183		428	17
18	CSI (repair air conditioner)			1998	1,698	170	10	170		396	18
19	CSI (replace gaskets on hot water coil)			1998	3,934	197	20	197		426	19
20	North Town Food Service (repair dish machine)			1999	1,861	186	10	186		372	20
21	Alden Bennet Construction (tank replacement)			1999	8,550	346	25	346		634	21
22	Patten (Fuel Tank Repairs, need invoice)			1999	1,724	172	10	172		287	22
23	Chicago Cooling Corp. (repair of unit 5, and inspection)6/99			1999	2,367	237	10	237		375	23
24	Climate Service,Inc. (replace 15 ton condenser)			1999	9,374	625	15	625		937	24
25	Climate Service, Inc.(replace 10 ton condenser)			1999	7,100	473	15	473		710	25
26	Climate Service, Inc. (compressor)			1999	7,466	498	15	498		705	26
27	Climate Service, Inc.(vac pump)			1999	1,644	110	15	110		146	27
28	Climate Service, Inc.(compressor maintenance)			1999	1,728	115	15	115		144	28
29	Capps Plumbing & Sewer(install trap & rodded pipes)			1999	1,835	184	10	184		229	29
30	Climate Service, Inc.(tank repair and maintenance)			1999	2,380	95	25	95		103	30
31	Shine Rite Maintenance(refinish tile floors)			1999	4,805	481	10	481		521	31
32	Alden Bennet Construction (tile/roofing)			2000	8,214	685	10	685		685	32
33	Alden Bennet Construction (tile/roofing)			2000	11,459	382	10	382		382	33
34	continued...										34
35											35
36	TOTAL (lines 4 thru 35)				$ 120,514	$ 9,468		$ 9,468	$	$ 19,317	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fox Valley Fire & Safety (replace smoke detectors)			2000	3,731	280	10	280		280	9
10	CSI Coker Service (repair dishwasher)			2000	3,299	247	10	247		247	10
11	Welding Supply Inc (repair alarm system)			2000	2,750	183	10	183		183	11
12	Welding Supply Inc (repair alarm system)			2000	6,649	443	10	443		443	12
13	System Electric Inc (new controls for oxygen system)			2000	1,785	149	8	149		149	13
14	GT Mechanical (repair laundry compressor)			2000	2,700	135	10	135		135	14
15	CSI Coker Service (repair dishwasher)			2000	1,536	77	10	77		77	15
16	Equipment International (repair laundry equipment)			2000	1,670	70	10	70		70	16
17	GT Mechanical (repair pneumatic system compressor)			2000	2,431	101	10	101		101	17
18	Advanced Parts & Service (repair food processor)			2000	2,026	84	10	84		84	18
19	CSI Coker Service (repair boiler)			2000	5,985	100	10	100		100	19
20											20
21											21
22	continued…										22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 34,562	$ 1,869		$ 1,869	$	$ 1,869	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 160,593	$ 18,776	$ 18,776	$	varies	$ 71,922	37
38	Current Year Purchases	51,829	3,574	3,574			3,574	38
39	Fully Depreciated Assets	23,139	1,214	1,214			23,139	39
40								40
41	TOTALS	$ 235,561	$ 23,564	$ 23,564	$		$ 98,635	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 578,803	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 56,322	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 56,322	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 399,262	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	n/a	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL ENTERPRISES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976-1978	316	3/1/95	$ 2,316,436	15	15	3
4	Additions							4
5								5
6								6
7	TOTAL		316		$ 2,316,436 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: see pg 14a for purchase option… *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 2/28/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ 2,341,702
13.	12/31/02	$ 2,380,810
14.	12/31/03	$ 2,421,179

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 11,180 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RELATED PARTY-	VARIOUS	$ 2150	$ 25,803	17
18					18
19					19
20					20
21	TOTAL		$ 2150	$ 25,803	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 63,225	$		$ 63,225	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			23,590			23,590	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			95,637			95,637	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16A…	# of prescrpts				49,247		49,247	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see pg 16A…					18,301		18,301	13
14	TOTAL			$		$ 182,452	$ 67,548		$ 250,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB **#** 0040691 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,969	$	1
2	Cash-Patient Deposits	81,675		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (96,208))	1,605,329		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	210,517		6
7	Other Prepaid Expenses	9,875		7
8	Accounts Receivable (owners or related parties)	295,717		8
9	Other(specify): inv in nurs home/due fr bc	936,459		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,148,540	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	350,557		15
16	Equipment, at Historical Cost	165,471		16
17	Accumulated Depreciation (book methods)	(205,838)		17
18	Deferred Charges	81,524		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 391,715	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,540,255	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,887,868	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	110,641		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,652		30
31	Accrued Taxes Payable (excluding real estate taxes)	71,750		31
32	Accrued Real Estate Taxes(Sch.IX-B)	199,074		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(220,878)		35
	Other Current Liabilities(specify):			
36	third party	931,243		36
37	due to idpa/others	472,522		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,706,872	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,706,872	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,166,616)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,540,255	$	48

***(See instructions.)**

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 113,223	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 cost report		3
4	was filed- only non-reimbursable costs were effected:		4
5	bad debts and medicare revenues	84,295	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 197,518	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,364,134)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,364,134)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,166,616)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,832,335	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,832,335	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(46,301)	6
7	Oxygen	5,733	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (40,568)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,501	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(1,371)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	47,499	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 48,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	adjustments to prior year expenses	16,465	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,465	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,856,905	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,616,450	31
32	Health Care	2,857,563	32
33	General Administration	1,568,393	33
	B. Capital Expense		
34	Ownership	2,688,503	34
	C. Ancillary Expense		
35	Special Cost Centers	316,646	35
36	Provider Participation Fee	173,484	36
	D. Other Expenses (specify):		
37	Note: this will not balance to page 3 & 4 due to related party		37
38	amounts entered to page 3 & 4.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,221,039	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,364,134)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,364,134)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not yet done **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,009	2,112	$ 51,091	$ 24.19	1
2	Assistant Director of Nursing	1,920	2,166	49,727	22.96	2
3	Registered Nurses	37,268	40,596	825,132	20.33	3
4	Licensed Practical Nurses	15,256	16,096	296,812	18.44	4
5	Nurse Aides & Orderlies	83,546	85,651	1,290,268	15.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,696	1,783	22,599	12.67	9
10	Activity Assistants	10,931	11,792	93,670	7.94	10
11	Social Service Workers	2,081	2,294	29,163	12.71	11
12	Dietician					12
13	Food Service Supervisor	1,250	1,250	16,447	13.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,431	32,685	263,761	8.07	15
16	Dishwashers					16
17	Maintenance Workers	1,848	2,080	27,176	13.07	17
18	Housekeepers	31,039	32,233	192,439	5.97	18
19	Laundry	12,101	12,655	85,309	6.74	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,200	5,861	93,824	16.01	22
23	Office Manager	3,757	3,914	41,662	10.64	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,816	2,616	64,122	24.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: clinic support	1,912	2,080	40,426	19.44	32
33	Other(specify) alzh.superv.	520	520	9,059	17.42	33
34	TOTAL (lines 1 - 33)	245,581	258,384	$ 3,492,687 *	$ 13.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,511	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Alzheimers Consultant	1	52	12-3	47
48					48
49	TOTAL (lines 35 - 48)	50	$ 2,562		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	n/a	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
D. HANSEN	administrator	0	$ 55,903
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,903

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services, Inc.	management fee	$ 688,988
Blackman Kallick Bartelstein	accounting fee	11,400
Fisch/Greenberg/Hermann	legal fees(inv's attached)	49,532
Achieve Accreditation	JHACO	480
aj prior year strat.alliance exp.	blood glucose coordin.	(5,824)
Blackman Kallick Bartelstein	professional business cons.	1,102
US GAS & ENERGY	utility consultant	1,507
Alden Design	architect. Fees	112
Alden Bennett	construction fees	5,640
SMS	medicare consultant	7,500
gates/mcdonald	unemployment comp.	1,738
RELATED PARTY-		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 762,175

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,093
Unemployment Compensation Insurance	18,599
FICA Taxes	270,732
Employee Health Insurance	51,144
Employee Meals	49,747
Illinois Municipal Retirement Fund (IMRF)*	
DENTAL/LIFE/MISC EMPL COSTS	318
EMPLOY' RELATIONS/TUITION REIMB.	499
401K MATCH/PHYSICALS	1,296
RELATED PARTY-	65,773
TOTAL (agree to Schedule V, line 22, col.8)	$ 515,201

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	982
Health Care Worker Background Check	0
(Indicate # of checks performed)	0
IHCA	9,941
AMERICAN HEALTH CARE ASS	400
misc dues & subscriptions	(33)
OTHER VARIOUS LIC&INSPECTIONS	605
RELATED PARTY-	730
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
ASAP PRINTING	510
IHCA	545
RELATED PARTY-	18,823
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,878

**See instructions.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB # 0040691 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	see page 22a…	1995-1999	$ 106,698	3-10	$ 14,875	$ 23,658	$ 23,404	$ 19,001	$ 9,319	$ 2,833	$ 1,267	$ 1,267	$ 1,267
2	see page 22b…	2000	26,516	3				3,803	8,839	8,839	5,036	0	0
3													
4													
5													
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14													
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16													
17													
18													
19													
20	TOTALS		$ 133,214		$ 14,875	$ 23,658	$ 23,404	$ 22,804	$ 18,158	$ 11,672	$ 6,303	$ 1,267	$ 1,267

Facility Name & ID Number ALDEN TERRACE OF MCHENRY REHAB **#** 0040691 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **9941**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,248** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **173,484**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **49,747** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NA** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **NA**
c. What percent of all travel expense relates to transportation of nurses and patients? **NA**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NA
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Blackman Kallick Bartelstein** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number ALDEN TERRACE OF MCHENRY Report Period Beginning 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	BOB'S PAINTING & DECORATI	11/95	9,250	3	3,083	2,569	0						
2	BOB'S PAINTING(PAINTING)	10/95	4,610	3	1,537	1,152	0						
3	Bob's Painting (touch up painting)	2/96	1,430	3	477	477	40	0	0	0	0	0	0
4	Climae(ice machine, work on a/c)	5/96	3,451	10	345	345	345	345	345	345	345	345	345
5	Climate Service, Inc. (boiler repair)	5/96	2,437	10	244	244	244	244	244	244	244	244	244
6	Bob's Painting (painting)	5/96	1,610	3	537	537	179	0	0	0	0	0	0
7	Superior Painting (painting)	9/96	1,078	3	359	359	239	0	0	0	0	0	0
8	Bob's Painting (painting)	1/96	1,430	3	477	477	0	0	0	0	0	0	0
9	Climate Serv(H.V.A.C. revision)	2/96	1,590	10	159	159	159	159	159	159	159	159	159
10	Bob's Painting (painting)	3/96	1,610	3	537	537	89	0	0	0	0	0	0
11	Bob's Painting (painting)	8/96	1,610	3	537	537	313	0	0	0	0	0	0
12	Bob's Painting (painting)	4/96	1,610	3	537	537	134	0	0	0	0	0	0
13	Bob's Painting (painting)	7/96	1,610	3	537	537	268	0	0	0	0	0	0
14	Bob's Painting (painting)	12/96	1,104	3	368	368	337	0	0	0	0	0	0
15	Bob's Painting (painting)	9/96	1,610	3	537	537	358	0	0	0	0	0	0
16	Bob's Painting (painting)	11/96	1,380	3	460	460	383	0	0	0	0	0	0
17	CLIMATE(INSTALL MOTOR HV	4/96	3,406	10	341	341	341	341	341	341	341	341	341
18	HSK SERV.(MOTOR-DISHWASH	5/96	1,789	10	179	179	179	179	179	179	179	179	179
19	climate(replace inducer motor)	1/97	3,051	3	1,017	1,017	1,017	0					
20	Climate srvc(belts & defrost timer	5/97	1,608	3	357	536	536	179	0	0	0	0	0
21	Climate(hot water mixing valve)	6/97	2,886	3	561	962	962	401	0				
22	Climate (repair a/c)	7/97	1,593	3	265	531	531	265	0				
23	Climate Service (boiler repair)	10/97	1,505	3	125	502	502	376	0				
24	painting by Onassis	10/97	15,609	3	1,301	5,203	5,203	3,902	0				
25	Great Lakes(sink/valve replace)	2/98	1,961	3		599	654	654	54	0			
26	Climate Serv.(a/c air handlers)	4/98	1,733	3	0	433	578	578	144	0	0	0	0
27	Painting- Onassis	3/98	7,492	3		2,081	2,497	2,497	416	0			
28	Painting- Onassis	6/98	4,628	3		900	1,543	1,543	643	0			
29	Painting- Onassis	9/98	2,651	3		295	884	884	589	0			
30	Painting- Onassis	12/98	9,008	3		250	3,003	3,003	2,752	0			
31	Climate Serv.-tank repair	4/99	1,925	3			481	642	642	160	0		
32	Painting>$1,500 ytd 1999	7/99	8,432	3			1,405	2,811	2,811	1,405	0		
	continue with page 22b…												
33	TOTAL		106,698		14,875	23,658	23,404	19,001	9,319	2,833	1,267	1,267	1,267

Facility Name & ID Number ALDEN TERRACE OF MCHENRY Report Period Beginning 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	painting>$1,500 for 2000	7/00	8,926	3				1,488	2,975	2,975	1,487	0	
2	Climate Serv.-repair hvac	1/00	1,626	3				542	542	542	0	0	
3	ABC-paving/wallcover	9/00	8,309	3				923	2,770	2,770	1,847	0	
4	ABC-painting/wallcover	9/00	7,654	3				850	2,551	2,551	1,701	0	
5													
6													
7													
8													
9													
33	TOTAL		26,516		0	0	0	3,803	8,839	8,839	5,036	0	0